

made 2 weeks after the end of a bi-weekly period of service, as described in § 413.64(h)(6). These PIP provisions are further described in § 413.64(h)(6). Under certain circumstances that are described in § 413.64(g), a CAH that is not receiving PIP may request an accelerated payment.

(e) *Payment for service of distinct part psychiatric and rehabilitation units of CAHS.* Payment for inpatient services of distinct part psychiatric units of CAHs—

(1) For cost reporting periods beginning on or after January 1, 2005, payment is made on a reasonable cost basis, subject to the provisions of § 413.40.

(2) For cost reporting periods beginning on or after January 1, 2005, payment is made in accordance with regulations governing inpatient psychiatric facilities at subpart N (§ 412.400 through § 412.432) of Part 412 of this subchapter.

(3) Payment for inpatient services of distinct part rehabilitation units of CAHs is made in accordance with regulations governing the inpatient rehabilitation facilities prospective payment system at Subpart P (§ 412.600 through § 412.632) of Part 412 of this subchapter.

[65 FR 47109, Aug. 1, 2000, as amended at 66 FR 32195, June 13, 2001; 66 FR 39936, Aug. 1, 2001; 67 FR 50118, Aug. 1, 2002; 68 FR 45471, Aug. 1, 2003; 69 FR 49252, Aug. 11, 2004; 69 FR 66981, Nov. 15, 2004; 74 FR 44000, Aug. 27, 2009; 75 FR 44564, July 28, 2010; 75 FR 50417, Aug. 16, 2010; 75 FR 73616, Nov. 29, 2010; 76 FR 51783, Aug. 18, 2011]

EFFECTIVE DATE NOTE: At 77 FR 54146, Sept. 4, 2012, § 412.70 was amended by revising the introductory text of paragraph (a)(6)(i), and paragraphs (a)(6)(ii) and (iii), effective November 5, 2012. For the convenience of the user, the revised text is set forth as follows:

**§ 413.70 Payment for services of a CAH.**

(a) \* \* \*

(6)(i) For cost reporting periods beginning in or after FY 2015, if a CAH is not a qualifying CAH for the applicable EHR reporting period, as defined in § 495.4 and § 495.106(a) of this chapter, then notwithstanding the percentage applicable in paragraph (a)(1) of this section, the reasonable costs of the CAH in providing CAH services to its inpatients are adjusted by the following applicable percentage:

\* \* \* \* \*

(ii) The Secretary may on a case-by-case basis, exempt a CAH that is not a qualifying CAH from the application of the payment adjustment under paragraph (a)(6)(i) of this section if the Secretary determines that compliance with the requirement for being a meaningful user would result in a significant hardship for the CAH. In order to be considered for an exception, a CAH must submit an application demonstrating that it meets one or more of the criteria specified in this paragraph (a)(6) for the applicable payment adjustment year no later than November 30 after the close of the applicable EHR reporting period. The Secretary may grant an exception for one or more of the following:

(A) During any 90-day period from the beginning of the cost reporting period that begins in the fiscal year before the payment adjustment year to November 30 after the end of the payment adjustment year, the hospital was located in an area without sufficient Internet access to comply with the meaningful use objectives requiring Internet connectivity, and faced insurmountable barriers to obtaining such Internet connectivity.

(B) A CAH that faces extreme and uncontrollable circumstances that prevent it from becoming a meaningful EHR user during the payment adjustment year.

(C) The CAH is new in the payment adjustment year and has not previously operated (under previous or present ownership). This exception expires beginning with the first Federal fiscal year that begins on or after the hospital has had at least one 12-month (or longer) cost reporting period after they accept their first Medicare-covered patient. For the purposes of this exception, the following CAHs are not considered new CAHs:

(I) A CAH that builds new or replacement facilities at the same or another location even if coincidental with a change of ownership, a change in management, or a lease arrangement.

(2) A CAH that closes and subsequently re-opens.

(3) A CAH that has been converted from an eligible hospital as defined at § 495.4 of this chapter.

(iii) Exceptions granted under paragraph (a)(6)(ii) of this section are subject to annual renewal, but in no case may a CAH be granted such an exception for more than 5 years.

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**§ 413.74 Payment to a foreign hospital.**

(a) *Principle.* Section 1814(f) of the Act provides for the payment of emergency and nonemergency inpatient hospitals services furnished by foreign hospitals to Medicare beneficiaries. Subpart H of part 424 of this chapter,

together with this section, specifies the conditions for payment.

(b) *Amount of payment.* Effective with admissions on or after January 1, 1980, the reasonable cost for services covered under the Medicare program furnished to beneficiaries by a foreign hospital will be equal to 100 percent of the hospital's customary charges (as defined in § 413.13(b)) for the services.

(c) *Submittal of claims.* The hospital must establish its customary charges for the services by submitting an itemized bill with each claim it files in accordance with its election under § 424.104 of this chapter.

(d) *Exchange rate.* Payment to the hospital will be subject to the official exchange rate on the date the patient is discharged and to the applicable deductible and coinsurance amounts described in §§ 409.80 through 409.83.

[51 FR 34793, Sept. 30, 1986, as amended at 51 FR 41351, Nov. 14, 1986; 53 FR 6648, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988; 71 FR 48141, Aug. 18, 2006]

## Subpart F—Specific Categories of Costs

### § 413.75 Direct GME payments: General requirements.

(a) *Statutory basis and scope—(1) Basis.* This section and §§ 413.76 through 413.83 implement section 1886(h) of the Act by establishing the methodology for Medicare payment of the cost of direct graduate medical educational activities.

(2) *Scope.* This section and §§ 413.76 through 413.83 apply to Medicare payments to hospitals and hospital-based providers for the costs of approved residency programs in medicine, osteopathy, dentistry, and podiatry for cost reporting periods beginning on or after July 1, 1985.

(b) *Definitions.* For purposes of this section and §§ 413.76 through 413.83, the following definitions apply:

*All or substantially all of the costs for the training program in the nonhospital setting means—*

(1) Effective on or after January 1, 1999 and for cost reporting periods beginning before July 1, 2007, the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries and fringe

benefits attributable to direct graduate medical education (GME); and

(2) Effective for cost reporting periods beginning on or after July 1, 2007 and before July 1, 2010, at least 90 percent of the total of the costs of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries attributable to nonpatient care direct GME activities.

*Approved geriatric program* means a fellowship program of one or more years in length that is approved by one of the national organizations listed in § 415.152 of this chapter under that respective organization's criteria for geriatric fellowship programs.

*Approved medical residency program* means a program that meets one of the following criteria:

(1) Is approved by one of the national organizations listed in § 415.152 of this chapter.

(2) May count towards certification of the participant in a specialty or subspecialty listed in the current edition of either of the following publications:

(i) The Directory of Graduate Medical Education Programs published by the American Medical Association, and available from American Medical Association, Department of Directories and Publications, 515 North State Street, Chicago, Illinois 60610; or

(ii) The Annual Report and Reference Handbook published by the American Board of Medical Specialties, and available from American Board of Medical Specialties, One Rotary Center, Suite 805, Evanston, Illinois 60201.

(3) Is approved by the Accreditation Council for Graduate Medical Education (ACGME) as a fellowship program in geriatric medicine.

(4) Is a program that would be accredited except for the accrediting agency's reliance upon an accreditation standard that requires an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether the standard provides exceptions or exemptions.

*Base period* means a cost reporting period that began on or after October 1, 1983 but before October 1, 1984.